A Spoonful of Cinnamon Makes the Medicine Go Down

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ABSTRACT

Schizotypal personality disorder is marked by symptoms resembling psychosis. A case report of a patient with odd medical beliefs related to schizotypal personality disorder is presented. These beliefs jeopardized the patient’s physical health and impacted decision-making capacity. Ethical dilemmas and challenges surrounding the case are discussed.

Mr. J. is a 53-year-old male with type 1 diabetes mellitus and more than 30 hospitalizations for diabetic ketoacidosis (DKA) related to medication noncompliance. Psychiatry was consulted to determine his capacity to refuse insulin and aid in management and disposition to prevent the repeated pattern of hospitalization.

Mr. J. presented as eccentric with an overelaborate manner of speaking and bright colorful clothing. He believed he could discern when others were being influenced by evil spirits. He endorsed visions of demons and was suspicious of staff. He also expressed firmly held beliefs about his physical health. He lacked insight and insisted he did not have diabetes, but instead, a hormonal problem in which his body produced too much acid leading to DKA. His preferred remedy for diabetes included spices such as cinnamon and curry. He contended that insulin caused blood glucose elevation and cited allergies to insulin. Review of the medical record revealed a chronic persistence of these beliefs.

His capacity to refuse treatment was called into question after repeated admissions to the intensive care unit with glucose levels at times greater than 1000 mg/dL, DKA, and coma. Family members routinely called emergency services and brought Mr. J. to the hospital for unresponsiveness. Once medically stabilized, Mr. J. would then become upset with his family for having him treated with conventional medicine. Psychiatric symptoms were treated in the past with the antipsychotic agents risperidone, haloperidol, and perphenazine, with little or no benefit.

Mr. J. presented as eccentric with long-standing odd medical beliefs. Psychological testing was
performed, including a neuropsychological screen of cognition, projective testing, and the Personality Assessment Inventory. Tests demonstrated intact cognition and reality testing and significant anxiety. These findings, combined with the overall clinical picture, resulted in the following diagnosis.

**DIAGNOSIS**

**Schizotypal Personality Disorder**

Schizotypal personality disorder (SPD) is estimated to affect 3% to 5% of the population. This Cluster A personality disorder is marked by psychotic-like symptoms including odd beliefs or magical thinking, ideas of reference, unusual perceptual experiences, overelaborate or metaphorical speech, paranoia, eccentric behavior, excessive social anxiety, and lack of close relationships. Symptoms result in pervasive social and interpersonal deficits. Studies have shown a higher risk for schizophrenia and related disorders in first-degree relatives of patients with SPD. Up to 40% of patients with SPD eventually develop schizophrenia, suggesting that SPD may be a schizophrenia spectrum disorder.

Few studies have examined treatment of SPD with antipsychotic agents. Limitations include small sample size and open-label design, but some studies show tolerability and efficacy in treating symptoms. One study investigating low-dose risperidone found significant improvement in Positive and Negative Syndrome Scale scores after 3 weeks. Another showed improvement in Brief Psychiatric Rating Scale and Global Assessment of Symptoms scores after treatment with olanzapine, with weight gain cited as a major side effect.

In addition to diagnosis of SPD, Mr. J. was determined to have diminished capacity to refuse insulin. He exhibited illness denial and inability to appreciate potential consequences of insulin refusal. His spouse (also his health care power of attorney) consented to continued treatment. As a result, despite Mr. J.’s refusal, he was treated with insulin but continued to refuse all other medications.

Safe disposition was another major concern. Given the pattern of medication noncompliance after hospital discharge, there was apprehension about discharging Mr. J. to home. The treatment team agreed that his condition was unlikely to be modified by involuntary inpatient psychiatric hospitalization. Placement options were limited by lack of insurance coverage for long-term care. In addition, Mr. J. was opposed to placement and wanted to be home with his family. Legal and ethical implications of discharge to home versus continued hospitalization against his will were weighed. Ultimately, he was discharged to home with his family.

**DISCUSSION**

This case raises questions regarding decision-making capacity and involuntary medical treatment of a patient with an underlying psychiatric illness.

**Capacity**

Psychiatrists are often consulted to determine whether a patient is “competent” to make medical decisions. Competency is a legal determination that is established by the courts. Decision-making capacity can be determined by a clinician and is one element that is used in determining legal competency. Decision-making capacity is specific to a particular decision, and a particular patient may have capacity to make one decision and lack capacity to make another.

There are four generally accepted abilities (the “four abilities” model) necessary for capacity to be intact. These include understanding, appreciating, reasoning, and evidencing a choice. To have intact capacity, the patient should have the ability to (1) understand information relevant to the treatment decision, (2) appreciate how the treatment decision will affect one’s own situations, (3) reason logically in weighing treatment options, and (4) have the ability to express a choice regarding treatment. Although all four abilities are necessary, some have argued that different levels of capacity may be used based on the severity of the consequences of the decision at hand. Namely, less significant decisions may require lower levels of capacity to preserve patient autonomy. Decisions with potentially greater impact (those that may result in serious or irreversible harm) may require higher levels of capacity.

Assessment instruments have been developed to aid in the determination of capacity. Some focus solely on the patient’s level
of understanding, whereas others are expanded to include all four components that must be assessed in capacity determinations. The MacArthur Competence Assessment Tool–Treatment is well studied and assesses all four required domains. It uses a semi-structured interview format that takes approximately 15 to 20 minutes to complete. Another instrument with similar format is the Structured Interview for Competency and Incompetency Assessment Testing and Ranking Inventory. In place of structured interviews, instruments such as the Competency to Consent to Treatment Instrument utilize hypothetical vignettes while still assessing all required domains.

Based on the “four abilities” model, Mr. J. lacks understanding, appreciation, and reasoning. He demonstrates illness denial and generates alternative theories to explain his symptoms. However, he is able to clearly express a choice, which is to be discharged and not take his medications. Given his diminished capacity to refuse insulin, his spouse/health care power of attorney becomes the substituted decision maker and gives consent for treatment. This then raises ethical questions regarding coerced on-going medical treatment and what steps, if any, should be taken to ensure compliance after discharge.

Coerced Treatment
Psychiatric patients may require involuntary hospitalization and treatment when there is imminent risk of danger to self or others resulting from mental illness. Involuntary treatment may include use of physical restraints to administer medications in emergency situations, as well as verbal coercion to take medications. Studies demonstrate both benefit and harm from involuntary treatment of mental illness. Patients reported negative effects including feelings of fear, helplessness, anger, and embarrassment on administration of forced medications. On the other hand, retrospective patient interviews revealed better patient perceptions. One study found that more than half of patients retrospectively agreed that forced medication was in their best interest, and another study found 60% of patients retrospectively agreed with having been coerced to take medication. The dangerousness criterion—imminent risk of danger to self or others—legally and ethically allows clinicians to override the patient’s autonomy and use coercive measures, thereby upholding the principle of beneficence.

Although involuntary psychiatric hospitalization and administration of psychotropic medication, when necessary, is generally accepted practice and has been examined in the literature, there is paucity in addressing involuntary medical treatment of psychiatric patients with diminished capacity. A 2006 case report described a patient with possible dementia and a psychotic disorder (paranoid schizophrenia versus residual schizophrenia versus SPD) who refused treatment for severe anemia, hernia, and cellulitis. The patient was determined to lack decision-making capacity due to illness denial and ultimately required appointment of a conservator and placement in a nursing home where treatment refusal persisted. Unlike the case of Mr. J., lack of immediate medical treatment did not pose imminent danger to the patient. Another 2006 case report described a patient with bipolar disorder, polysubstance dependence, and dementia who refused medical treatment and demanded discharge. The authors emphasized lack of guidelines for continued involuntary medical hospitalization of patients who do not meet criteria for involuntary psychiatric commitment. The overall recommendation was to attempt to keep the patient hospitalized, provide treatment in emergency situations, and pursue court-appointed guardianship.

In the case of Mr. J., an argument could be made for involuntary psychiatric commitment based on imminent self-harm risk (by insulin refusal) due to odd medical beliefs resulting from SPD. This could entail patient transfer to a psychiatric unit and involuntary administration of psychotropic medications. The treatment team agreed this would not be in the best interest of the patient, as the care he needed was primarily medical and not psychiatric. Furthermore, he had failed trials of antipsychotic agents in the past and a re-trial
was unlikely to be effective. As a result, he remained on the medical unit and his spouse/power of attorney gave permission for continued hospitalization and insulin administration. The patient voiced objections but acquiesced to his spouse’s decision. Prior to discharge, the patient’s spouse was encouraged to pursue guardianship.

CONCLUSION

This case highlights unique aspects of SPD and the impact it can have on physical health when eccentric beliefs about medical conditions exist. It further highlights the challenges that can present when patients lack decision-making capacity and require ongoing medical treatment. The difficulties encountered in this case demonstrate the importance of further clinical discussion, research, and long-term outcome tracking to aid in the development of clear guidelines for clinicians facing similarly complex situations. Clinicians are tasked with determining whether the patient requires involuntary psychiatric treatment and the potential benefit of such treatment. An interdisciplinary approach with involvement of the primary medical team, psychiatrist, psychologist, social work, patient, and family members is essential in determining the most appropriate course of action.

REFERENCES


